Notice of Office Financial Policy and Procedures

Thank you for choosing **Sunshine Dental** for your dental care provider. We are committed to providing you with the best possible care to your dental treatment being successful. Your clear understanding of our financial policy is important to our professional relationship. Please understand that payment of your bill is considered part of your treatment.

We accept Cash, Check, Money Order, Visa, MasterCard and Care Credit.

Insurance: Our practice is committed to providing the best dental treatment for our patients; however, as your dental care provider, we must emphasize the following:

1. Our relationship is with you, our patient, not with your insurance company. We cannot accept the responsibility of negotiating the claims with insurance companies or any other persons. While the filling of insurance claims is a "courtesy" that we extend to our patients, all charges are your responsibility from the date of the services rendered.
2. Your insurance coverage is a contract between you and your insurance company. It is very important that you understand the provisions of your policy. We cannot guarantee payment of claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policyholder. Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation.
3. Not all services are a covered benefit in all contacts. Some insurance companies arbitrarily select certain services they will not cover. Some of the services may be considered "non-covered" services and not considered necessary dental insurance programs. Please remember that dental services are rendered and charged to the patient, not the insurance company.
4. If you have a dental insurance that we participate with, ***your payment of deductibles, non-covered services and co-payments are due when services are rendered***. If we do not participate with your insurance company or if you do not have dental insurance coverage, payment in full for services is due at the time services are rendered.
5. Although an insurance claim is filed, you will receive a monthly statement if your account has a balance due. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. The patient is responsible for payment.
    a. If your account becomes delinquent and you have not responded to our collection efforts, your account may be turned over to an outside source for collecting the balance due, and at which time you will be responsible for all fees related to that expense.

Returned Checks:

Any returned checks are subject to a **$35.00** service fee.

Any returned check **must** be resolved before any future appointments can be arranged.

Missed/Rescheduled Appointment Policy:

We respect our patients and all appointments made. We try our best to convenience our patients; therefore, we ask that you, the patient, respect us and your appointment times as well. To accomplish this, it is very important to be on time, arriving early for paperwork, and to notify us in the event you need to reschedule this appointment.

We reserve an ample amount of time for our patients because we feel it is important in providing quality dental care. Therefore, a 24 hour notice to change your appointment is necessary in order to accommodate your needs and to have the opportunity to offer this time to another patient.

Any cancellations (less then 24 hours notice) and/or "no show" appointments may result in a charge of up to $50.00. ***(This charge is not covered or paid by any insurance company. This charge will be billed directly to the patient and must be paid before any further appointments can be made.)***

If a patient no shows three appointments, unfortunately, you **may** be dismissed from our office. For any patient that has ***Indiana Medicaid Insurance***, your policies provisions do not allow us to charge this fee. In result, after your SECOND missed appointment, you and your family may be dismissed from our practice.

Office Financial Policy and Procedure Notice
Acknowledgment of Receipt

This is to acknowledge my receipt of the Office Policy Notice delivered to me by Sunshine Dental.

_____	_____
Patient Name (Please Print)	If Patient is a Minor, Responsible Party Name (Please Print)
_____	_____
Signature of Individual	Signature of Responsible Party
_____	_____
Date	Responsible Party Relationship to Patient

(**FOR OFFICE USE ONLY:** if no patient signature, fill out below)

RECORD OF GOOD FAITH ATTEMPT TO DELIVER

This is to record my good faith effort to obtain a written acknowledgment of receipt of the HIPAA Privacy Notice to:

Patient's Name: _____

Date: _____

SSN: _____

Acknowledgment of receipt of the Privacy Notice from the patient named above was not obtained for the following reason(s):

_____
_____
